DEPARTMENT OF HEALTH AND HUMAN SERVICES							
CENTERS FOR MEDICARE & MEDICAID SERVICES							
CTATEMENT OF DEFICIENCIES	V1) DD OVIDED (CLIDDLIED /CLIA	(V2) MULTIPLE COM					

X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 01 A. BUILDING 155712 07/15/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1675 W TIPTON ST **COVERED BRIDGE HEALTH CAMPUS** SEYMOUR, IN47274 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE K0000 The submission of this Plan of K0000 A Life Safety Code Recertification and Correction does not indicate an State Licensure Survey was conducted by admission by Covered Bridge the Indiana State Department of Health in Health Campus that the findings accordance with 42 CFR 483.70(a). and allegations contained herein are accurate and true representations of the quality of Survey Date: 07/15/11 care and services provided to the residents of Covered Bridge Facility Number: 003342 Health Campus. This facility Provider Number: 155712 recognized it's obligation to provide legally and medically AIM Number: 200403740 necessary care and services to its residents in an economic and Surveyor: Mark Bugni, Life Safety Code efficient manner. The facility hereby maintains it is in Specialist substantial compliance with the requirements of participation for At this Life Safety Code survey, Covered comprehensive health care Bridge Health Campus was found not in facilities (for Title 18/19 compliance with Requirements for programs). To this end, this Plan of Correction shall serve as the Participation in Medicare/Medicaid, 42 credible allegation of compliance CFR Subpart 483.70(a), Life Safety from with all state and federal Fire and the 2000 edition of the National requirements governing the Fire Protection Association (NFPA) 101, management of this facility. It is thus submitted as a matter of Life Safety Code (LSC), and 410 IAC statue only. 16.2. The original building consisting of everything but the four resident rooms 300 Hall addition was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility is a fully sprinklered building of Type V (111) construction. The facility has a fire alarm system with smoke detection in the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: ZF

ZHT721

Facility ID:

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TITLE

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712	(X2) MU A. BUILI B. WING	DING	NSTRUCTION 01	(X3) DATE : COMPL 07/15/2	ETED
NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS				1675 W	DDRESS, CITY, STATE, ZIP CODE TIPTON ST UR, IN47274		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0038 SS=F	and all resident's healthcare portion capacity of 68 and the time of this volume of this volume. Quality Review by I Code Specialist-Med. The facility was four aforementioned regressible with section 7.1. Based on observer facility failed to accesses in the owith delayed egressible with delayed egressible with delayed-egressible with delayed egressible with delaye	Robert Booher, Life Safety dical Surveyor on 07/20/11. Ind not in compliance with the alatory requirements as	K00	038	The Director of Plant Operatic conacted the vendor to make repairs to the system. These repairs were completed on all hallway exit doors. All residents had the potential to affected. All egress doors we inspected when the fire alarm were activated to ensure the locks properly released. The Director of Plant Operations designee will complete a mo audit to ensure all egress do continue to release upon fire alarm activation. The results these audits will be reviewed the monthly QA/ Safety meet	o be ere ns or his nthly ors	07/18/2011

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		I	ATE SURVEY MPLETED
		155712	A. BUILDING	01		5/2011
		100/12	B. WING			J/2011
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP	CODE	
COVEDE	EN RDINGE HEALTI	H CAMPIIS	l l	V TIPTON ST OUR, IN47274		
COVERED BRIDGE HEALTH CAMPUS				OON, 11977274		1
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CO		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE
mo		Section 9.7 or upon the	1110			DAILE
	actuation of any	•				
	I -	more than two smoke				
		oproved, supervised				
	automatic fire de	-				
		Section 9.6. (b) The				
		k upon loss of power				
	controlling the lo	• •				
	1	An irreversible process				
	` ′	lock within 15 seconds				
		of a force to the release				
		n 7.2.1.5.4 that shall not				
	_	ceed 15 lbf nor be				
	1 ^					
	_	ntinuously applied for nds. The initiation of the				
	_	hall activate an audible				
	1 ~	nity of the door. Once				
		been released by the				
		rce to the releasing				
	ı	shall be by manual				
	I -	ception: Where approved				
	1 -	having jurisdiction, a				
	· ·	ng 30 seconds shall be				
	•	n the door adjacent to the				
		there shall be a readily				
		ign in letters not less				
	I -	and not less than 1/8 inch				
	in stroke width o	_				
	_	reads as follows: PUSH				
		SOUNDS DOOR CAN				
		15 SECONDS. This				
	1 ^	e affects all residents in				
	the 100 Hall, 200	Hall, and 400 Hall.				
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	ZHT721 Facility	/ ID: 003342 If co	ontinuation sheet	Page 3 of 8

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A DIVID DIVIC			(X3) DATE SURVEY COMPLETED	
THIS TERM OF COMMENTOR		155712	A. BUILD	ING		07/15/20	
			B. WING	CTDEET AI	DDRESS, CITY, STATE, ZIP CODE	01710720	
NAME OF F	PROVIDER OR SUPPLIER				TIPTON ST		
COVERE	D BRIDGE HEALTH	H CAMPUS			UR, IN47274		
(X4) ID	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		1	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG			+	TAG			DATE
	Findings include:						
	Based on observations on 07/15/11 during a tour of the facility with the plant operation director from 10:25 a.m. to 1:45 p.m., all three exits in the 100 Hall, 200 Hall, and 400 Hall healthcare portion of the facility were each equipped with delayed egress locks. Furthermore, the three exit doors failed to unlock during two separate tests of the fire alarm system on 07/15/11 at 1:10 p.m. and 1:25 p.m. Based on an interview with the plant operation director on 07/15/11 at 1:30 p.m., the magnetic exit doors are electrically wired to the fire alarm system main panel on a relay switch. The facility experienced a possible lightning strike a month ago and had several problems with the fire alarm system. The three exit						
	unlock upon activ	nal building failing to vation of the fire alarm					
	system was acknowledge administrator at t						
	conference on 07	•					
	conference on 07	/13/11.					
	3.1-19(b)						
K0000							
	State Licensure S	de Recertification and Survey was conducted by Department of Health in	K00	000	The submission of this Plan of Correction does not indicate admission by Covered Bridge Health Campus that the finding	an e	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE : COMPL	
			A. BUIL	LDING	02	07/15/2	
		1007 12	B. WING		PROPERTY OF THE CORP.	0771372	011
NAME OF I	PROVIDER OR SUPPLIE	₹			ADDRESS, CITY, STATE, ZIP CODE		
COVERE	ED BRIDGE HEALT	H CAMPUS	1675 W TIPTON ST SEYMOUR, IN47274				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				ID			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
	accordance with	42 CFR 483.70(a).			and allegations contained he are accurate and true	rein	
	Survey Date: 07	7/15/11			representations of the quality care and services provided to		
	D 11: N 1	002242			residents of Covered Bridge		
	Facility Number				Health Campus. This facility recognized it's obligation to		
	Provider Numbe				provide legally and medically	,	
	AIM Number: 2	200403740			necessary care and services residents in an economic and	to its	
	Surveyor: Mark	Bugni, Life Safety Code			efficient manner. The facility		
	Specialist				hereby maintains it is in	l	
					substantial compliance with t requirements of participation		
	At this Life Safe	ty Code survey, Covered			comprehensive health care	101	
	Bridge Health C	ampus was found not in			facilities (for Title 18/19		
	compliance with	th Requirements for Medicare/Medicaid, 42 83.70(a), Life Safety from			programs). To this end, this P		
	Participation in 1			of Correction shall serve as t credible allegation of complia			
	CFR Subpart 48				with all state and federal	arice	
	Fire and the 200	0 edition of the National			requirements governing the		
	Fire Protection A	on Association (NFPA) 101,			management of this facility. I		
		e (LSC), and 410 IAC			thus submitted as a matter of	f	
	16.2. The 300 H	Iall four resident room			statue only.		
	addition built in	2005 was surveyed with					
	Chapter 18, New						
	Occupancies.						
	This one story fa	acility is a fully					
		ling of Type V (111)					
construction. The facility has a fire alari							
	system with smo	oke detection in the					
corridors, spaces open to the corridors							
	_	sleeping rooms. The					
		pacity of 100 and had a					
		he time of this survey.					
	The facility was for	and not in compliance with the					
	<u> </u>						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712		(X2) MI A. BUII B. WIN	LDING	02	(X3) DATE: COMPL 07/15/2	ETED	
NAME OF PROVIDER OR SUPPLIER COVERED BRIDGE HEALTH CAMPUS				1675 W	ADDRESS, CITY, STATE, ZIP CODE / TIPTON ST DUR, IN47274	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	aforementioned regular evidenced by the following accessible with section 7.1. Based on observation facility failed to accesses supplied lock on 300 Hall activation of the 7.2.1.6.1, require delayed-egress lobe installed on doordinary hazard or protected through supervised autom in accordance with activation of any lactivation of any lactivation of not detectors of an apautomatic fire de accordance with	alatory requirements as lowing: Inged so that exits are at all times in accordance 18.2.1 Intion and interview, the ensure 1 of 1 exit if with a delayed egress unlocked upon fire alarm system. It is approved, listed, tocks shall be permitted to cors serving low and contents in buildings mout by an approved, matic fire detection system the Section 9.6, or an insed automatic sprinkler ance with Section 9.7, tend in Chapters 12 ided the following (a) The doors shall mation of an approved, matic sprinkler system in Section 9.7 or upon the heat detector or more than two smoke oproved, supervised tection system in Section 9.6. (b) The k upon loss of power	KO		CROSS-REFERENCED TO THE APPROPRIA	cions e e e o be ere ms e or his onthly oors e of d at	
	mechanism. (c)	An irreversible process lock within 15 seconds					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		155712	A. BUI	LDING	02	07/15/2	
		1507 12	B. WIN		DDDDGG GITTY GTATE ZID GODE	01/13/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE 'TIPTON ST		
COVERE	ED BRIDGE HEALTH	H CAMPUS		1	DUR, IN47274		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG			-	TAG	DEFICIENCY)		DATE
		of a force to the release					
	^	n 7.2.1.5.4 that shall not					
		ceed 15 lbf nor be					
	_	ntinuously applied for					
		nds. The initiation of the					
	_	hall activate an audible					
	~	nity of the door. Once					
		been released by the					
	1 ^ ^	rce to the releasing					
	'	shall be by manual					
	l -	reption: Where approved					
	by the authority having jurisdiction, a						
	1	ng 30 seconds shall be					
	_	n the door adjacent to the					
	· ·	there shall be a readily					
		ign in letters not less					
	I -	and not less than 1/8 inch					
	in stroke width o	•					
	_	reads as follows: PUSH					
		SOUNDS DOOR CAN					
		15 SECONDS. This					
	· •	e affects all residents in					
	the 300 Hall.						
	Findings include						
	- 1	•					
	Based on observa	ations on 07/15/11 during					
	a tour of the facil	lity with the plant					
	operation directo	r from 10:25 a.m. to 1:45					
	p.m., the 300 Ha	ll exit was equipped with					
	_	lock. Furthermore, the					
	300 Hall exit doc	or failed to unlock during					
	two separate tests	s of the fire alarm system					
	_	10 p.m. and 1:25 p.m.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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l l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155712	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 02	(X3) DATE COMPI 07/15/2	LETED
	PROVIDER OR SUPPLIE		1675 V	ADDRESS, CITY, STATE, ZIP CODE V TIPTON ST OUR, IN47274	•	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
		erview with the plant				
	operation direct	or on 07/15/11 at 1:30				
	p.m., the magne	tic exit door is electrically				
	wired to the fire	alarm system main panel				
	on a relay switc	h. The facility				
	experienced a p	ossible lightning strike a				
	1 ^ ^	had several problems with				
	1	stem. The 300 Hall exit				
	1	inlock upon activation of				
		ystem was acknowledged				
		rator at the 1:45 p.m. exit				
	1 -	•				
	conference on 0	7//13/11.				
	3.1-19(b)					

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